

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

2460

BIRTH NO. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis 1402 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION M6 Pacific Hospital		e. STREET ADDRESS 1116 Astoria Dr	
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Francis c. (Last) Steverson		4. DATE OF DEATH (Month) Mar (Day) 16 (Year) 55	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sep 26, 1909	
9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Clerk		10b. KIND OF BUSINESS OR INDUSTRY. Maloney Electric	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Hohn Steverson		13b. MOTHER'S MAIDEN NAME Mary Phillips	
14. NAME OF HUSBAND OR WIFE Marion Steverson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) Yes WW2	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Marion Steverson	
18. ADDRESS 1116 Astoria Dr		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Duodenal Ulcer abscess following Gastric Resection Perforating Ulcer - duodenal II. OTHER SIGNIFICANT CONDITIONS Chronic Uremia Interval between onset and death Feb 7/55 Jan 21/55 5-7 days	
19a. DATE OF OPERATION 31 Jan 55		19b. MAJOR FINDINGS OF OPERATION Chronic Perforating Duodenal ulcer on posterior duodenal wall	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21f. HOW DID INJURY OCCUR? 5411	
22. I hereby certify that I attended the deceased from Jan 25, 1955, to 16 March, 1955, that I last saw the deceased alive on 16 March, 1955, and that death occurred at 12:00 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Edward J. Jordan M.D.		23b. ADDRESS 1504 South Grand	
23c. DATE SIGNED 17 March		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 3-19-55		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Stroot-Carroll	
25. ADDRESS 4600 Natl Bridge		DATE REC'D BY LOCAL REG. MAR 18 1955	
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		Licensed Embalmer's Statement on Reverse Side	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.